	AIKEN COUNTY **Finance Department** **Central Collections** **Request for** **Amendment of Protected Health Information**	**AC-FNC103** (9/03)
	828 Richland Ave W. Aiken, SC 29801 803/642-2067 Fax: 803/642-2071	

Patient Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Information to Amend:

Please check the field that represents the type of information you would like to amend.

The Collections Division with the approval of the Divisions Designated Privacy Officer can change the following information:

__ Name
__ Mailing Address
__ Phone Number
__ Date of Birth
__ Marital Status
__ Guarantor Name
__ Guarantor Address
__ Guarantor Phone Number
__ Guarantor Date of Birth
__ Health insurance information
__ Other:

Emergency Services with the approval of the County Privacy Officer can change the following information:

__ Current Medical Condition
__ Past Medical History
__ Allergies
__ Primary Impression
__ Secondary Impression
__ Reason for Transport
__ Services Used (oxygen, EKG)
__ Other

Please specifically describe what information you want amended. Please **ONLY** list the new information. Attach a separate sheet if necessary.

_____

Emergency Services/Central Collections, in its capacity as a health care provider/billing agency, is entitled to perform and bill for services based on all protected health information in its current form or upon which it has already relied on until such time as the amended information becomes effective. Emergency Services/Central Collections is not required to accept your request for amendment and will notify you as to the decision on your request. We have sixty (60) days from the date of receipt of your amendment request to render our decision.

Your signature below indicates that you have agreed to accept these terms as they have been listed and to provide payment, if required, to Central Collections based on existing protected information until such time that the amendments you have requested are effective.

Patient Signature: _____ Date: _____